FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011288

Facility Name: Marklund Children's Home

Address: 164 S. Prairie (Number) Bloomingdale, IL (City) 60108 (Zip Code)

County: DuPage

Telephone Number: (630)529-2018 **Fax #** (630)529-9128

IDPA ID Number: 36-2652532

Date of Initial License for Current Owners: 10/1/68

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501-(c)(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Lisa Lipira Telephone Number: (630)529-2018 Ext. 2232

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date) 10/14/00

(Type or Print Name) Joel Rusco

(Title) President & CEO

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	98	Skilled Pediatric (SNF/PED)	90	32,940	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	90	32,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	29,881	1,845		31,726	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,881	1,845		31,726	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.31%

D. How many bed-hold days during this year were paid by Public Aid?
1,026 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/1/68

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 7/1/99-6/30/00 Fiscal Year: 7/1/99-6/30/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,120	14,832	16,655	199,607		199,607	0	199,607			1
2	Food Purchase		217,140		217,140		217,140	0	217,140			2
3	Housekeeping	100,494	33,343	39	133,876		133,876	0	133,876			3
4	Laundry	47,674	20,606		68,280		68,280	0	68,280			4
5	Heat and Other Utilities			115,838	115,838		115,838	0	115,838			5
6	Maintenance	68,255	27,054	79,363	174,672		174,672	0	174,672			6
7	Other (specify):*			26,503	26,503		26,503	0	26,503			7
8	TOTAL General Services	384,543	312,975	238,398	935,916		935,916		935,916			8
	B. Health Care and Programs											
9	Medical Director			31,603	31,603		31,603	0	31,603			9
10	Nursing and Medical Records	2,026,915	223,822	73,708	2,324,445	(47,362)	2,277,083	0	2,277,083			10
10a	Therapy	380,186	14,164	28,166	422,516		422,516	0	422,516			10a
11	Activities	24,960	22,779	22,999	70,738		70,738	0	70,738			11
12	Social Services	41,673			41,673		41,673	0	41,673			12
13	Nurse Aide Training		2,597		2,597	47,362	49,959	0	49,959			13
14	Program Transportation			48,441	48,441		48,441	0	48,441			14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	2,473,734	263,362	204,917	2,942,013		2,942,013		2,942,013			16
	C. General Administration											
17	Administrative	82,104			82,104		82,104	0	82,104			17
18	Directors Fees							0				18
19	Professional Services			28,517	28,517		28,517	0	28,517			19
20	Dues, Fees, Subscriptions & Promotions			82,091	82,091		82,091	0	82,091			20
21	Clerical & General Office Expenses	246,585	117,342	50,647	414,574		414,574	0	414,574			21
22	Employee Benefits & Payroll Taxes			742,136	742,136		742,136	0	742,136			22
23	Inservice Training & Education							0				23
24	Travel and Seminar			5,855	5,855		5,855	0	5,855			24
25	Other Admin. Staff Transportation			18,789	18,789		18,789	0	18,789			25
26	Insurance-Prop.Liab.Malpractice			58,092	58,092		58,092	0	58,092			26
27	Other (specify):*			897,006	897,006		897,006	(897,006)				27
28	TOTAL General Administration	328,689	117,342	1,883,133	2,329,164		2,329,164	(897,006)	1,432,158			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,186,966	693,679	2,326,448	6,207,093		6,207,093	(897,006)	5,310,087			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			321,165	321,165		321,165	(107,192)	213,973			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes			2,594	2,594	3,440	6,034	(6,034)				33
34	Rent-Facility & Grounds			46,463	46,463	(3,440)	43,023	0	43,023			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			370,222	370,222		370,222	(113,226)	256,996			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers	212,036	81,113		293,149		293,149	0	293,149			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			296,604	296,604		296,604	0	296,604			42
43	Other (specify):*							0				43
44	**TOTAL Special Cost Centers**	212,036	81,113	296,604	589,753		589,753		589,753			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,399,002	774,792	2,993,274	7,167,068	0	7,167,068	(1,010,232)	6,156,836			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(107,192)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(897,006)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,034)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,010,232)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,010,232)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**
The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

STATE OF ILLINOIS — **Page 5A**

Facility Name Marklund Children's Home
ID# 0011288
Report Period Beginning: 7/1/99
Ending: 6/30/00

Print Other Adjustments

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	0
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	0	Line 6	0
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	0	0	Line 8	0
9	Non-Straightline Depreciation	0	0	Line 9	0
10	Interest and Other Investment Income	0	0	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	0	0	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	0	Line 15	0
17	Non-Care Related Fees	(107,192)	30	Line 16	0
18	Fines and Penalties	0	0	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	0	0	Line 19	0
21	Owner or Key-Man Insurance	0	0	Line 20	0
22	Special Legal Fees & Legal Retainers	0	0	Line 21	0
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	0	0	Line 23	0
25	Fund Raising, Advertising and Promotional	(897,006)	27	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	(897,006)
29	Non-Paid Workers	0	0	Line 28	(897,006)
30	Donated Goods	0	0	Line 29	(897,006)
31	Amortization Expense	0	0	Line 30	(107,192)
32		0		Line 31	0
33	Real Estate Taxes	(6,034)	33	Line 32	0
34				Line 33	(6,034)
35				Line 34	0
36				Line 35	0
37				Line 36	0
38				Line 37	(113,226)
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(1,010,232)

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(897,006)	0	0	0	0	0	0	0	0	0	0	(897,006)	27
28	**TOTAL General Administration**	(897,006)	0	0	0	0	0	0	0	0	0	0	(897,006)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(897,006)	0	0	0	0	0	0	0	0	0	0	(897,006)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(107,192)	0	0	0	0	0	0	0	0	0	0	(107,192)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(6,034)	0	0	0	0	0	0	0	0	0	0	(6,034)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(113,226)	0	0	0	0	0	0	0	0	0	0	(113,226)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,010,232)	0	0	0	0	0	0	0	0	0	0	(1,010,232)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Marklund Children's Home # 4911200 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

Sum_6

1 Schedule V	2 Line	3 Cost Per General Ledger: Item	4 Amount	5 Cost to Related Organization: Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		$ -			$ -	$ -	1
2	V		-			-	-	2
3	V		-			-	-	3
4	V		-			-	-	4
5	V		-			-	-	5
6	V		-			-	-	6
7	V		-			-	-	7
8	V		-			-	-	8
9	V		-			-	-	9
10	V		-			-	-	10
11	V		-			-	-	11
12	V		-			-	-	12
13	V		-			-	-	13
14	Total		$ -			$ -	$ -	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	N/A					$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$ 0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 0	2
3. Under or (over) accrual (line 2 minus line 1).	$ 0	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$ 0	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ N/A For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$ 0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	4,340	8
1996	3,374	9
1997	0	10
1998	0	11
1999	0	12

Note: The taxable property that related to calendar years 1995 - 1996 (see above) was sold in 9/96.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,216 B. General Construction Type: Exterior Brick Frame Cement/Cinder Block Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	206,930	1968	$ 31,500	1
2					2
3	TOTALS	206,930		$ 31,500	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1968	1953	$ 68,500	$ 2,055	33	$ 2,055	$	$ 65,246	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Pavillion (land)			1989	6,485	324	20	324		3,728	9
10	Landscaping			1990	1,080	108	10	108		1,026	10
11	Ashphalt paving			1991	7,112		5			7,112	11
12	Ashphalt paving			1994	14,983	1,489	5	1,489		14,893	12
13	Ashphalt paving			1996	800	160	5	160		560	13
14	Driveway repair			1998	600	120	5	120		180	14
15	Parking lot concrete/asphalt			1999	32,199	3,220	5	3,220		3,220	15
16	Parking lot concrete/asphalt			1999	300	30	5	30		30	16
17	Ramp removal & installation of new ramp			1999	2,100	210	5	210		210	17
18	Parking lot ashphalt			2000	300	30	5	30		30	18
19	Remodeling Kitchen,new floor, cabinets			1973	27,619	11	25	11		27,481	19
20	Building construction POD II			1973	615,366	16,999	40	16,999		419,883	20
21	Oxygen work			1974	74,064	2,047	40	2,047		48,469	21
22	Basement			1974	6,500		25			6,500	22
23	Water Heater			1986	3,400		10			3,400	23
24	Service Buildings			1975	5,000	135	40	135		3,175	24
25	Service Buildings			1976	7,535	188	40	188		4,661	25
26	New Roof			1986	81,000	4,050	20	4,050		58,725	26
27	Lobby addition			1984	108,605	5,030	25	5,030		70,879	27
28	Carpeting			1987	3,171		10			3,171	28
29	Parents Room			1987	42,000	2,100	20	2,100		26,250	29
30	Stainless Steel Cabinets			1989	19,678	984	10	984		19,678	30
31	Garage Slab			1989	1,450	72	10	72		1,450	31
32	Wall/Fire Door installation			1990	1,200	120	10	120		1,140	32
33	POD general revovations floors/walls			1992	22,173	1,826	10	1,826		18,932	33
34	Elevator Door/Intallation			1993	1,219		5			1,219	34
35	Hot water tank			1993	6,206		5			6,206	35
36	TOTAL (lines 4 thru 35)				$ 1,160,645	$ 41,308		$ 41,308	$	$ 817,454	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Fire alarm			1993	850	85	10	85		638	9
10	Oxygen system/air duct work			1993	21,467	1,342	10	1,342		18,108	10
11	Carpet			1993	1,809		5			1,809	11
12	Asbestos testing			1994	1,250		5			1,250	12
13	Mailroom decorations			1994	2,090		5			2,090	13
14	Roof repairs			1994	19,116	1,912	5	1,912		19,116	14
15	HVAC work			1994	20,185	2,018	5	2,018		20,185	15
16	Exterior painting			1994	8,885	888	5	888		8,885	16
17	Metal Decking & Gutter			1994	2,650	265	5	265		2,650	17
18	Tracking/Privacy Curtains			1994	11,334	1,133	5	1,133		11,334	18
19	New Master Key System			1994	3,286	329	5	329		3,286	19
20	Cubicle tracking			1995	1,299	190	5	190		1,299	20
21	Heating system repair			1995	1,376	138	5	138		1,376	21
22	carpeting/flooring			1995	3,628	394	10	394		1,961	22
23	Heating & AC			1995	27,564	4,485	5	4,485		21,821	23
24	New Door Installation			1995	1,544	154	5	154		1,544	24
25	Shades/blinds PODs			1995	10,917	1,092	5	1,092		10,917	25
26	Steel Fire doors in Kitchen			1995	1,255	251	5	251		879	26
27	Client Room Shelves			1995	1,431	286	5	286		1,288	27
28	Electrical work			1996	6,778	1,356	5	1,356		6,101	28
29	Boiler			1996	887	177	5	177		798	29
30	Dental Office Cabinets			1996	4,165	833	5	833		3,749	30
31	Door/Frame laundry room			1996	845	169	5	169		761	31
32	front entry door controls			1996	2,120	424	5	424		1,908	32
33	fire alarm repairs			1996	1,086	217	5	217		977	33
34	Painting/Carpeting			1996	7,791	1,373	5	1,373		7,371	34
35	Wall, carpeting renovations			1998	4,887	977	5	977		1,466	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 20,488		$ 20,488	$	$ 153,567	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Gutters, roof down spouts			1999	8,800	1,760	5	1,760		2,640	9
10	new compressor			1999	2,580	177	15	177		258	10
11	Awnings			1999	2,520	504	5	504		756	11
12	Boiler			1998	2,675	534	5	534		802	12
13	Lobby walls			2000	57	6	5	6		6	13
14	Awnings rear entrance			2000	2,023	202	5	202		202	14
15	lower level classroom renovations			2000	189	18	5	18		18	15
16	awning for O2 protection			2000	3,477	348	5	348		348	16
17	Lobby walls			2000	7,997	500	5	500		500	17
18	HVAC-dining room			2000	610	61	5	61		61	18
19	Dining room walls & wall coverings			2000	2,060	206	5	206		206	19
20	HVAC coil dining room			2000	1,590	159	5	159		159	20
21	Dining room flooring window shades			2000	3,560	356	5	356		356	21
22	fire doors lower level			2000	564	28	5	28		28	22
23	carpet flooring lower level			1999	5,855	585	5	585		585	23
24	lower level classroom renovation			1999	1,346	135	5	135		135	24
25	replacement windows			1999	538	54	5	54		54	25
26	Construction, engineering, architect, inspection			1999	49,390	2,470	10	2,470		2,470	26
27	fire sprinkler system			1999	72,843	1,457	25	1,457		1,457	27
28	interior design, handrails, corner pieces			1999	29,873	996	15	996		996	28
29	Demolition old lower level			1999	26,641	1,332	10	1,332		1,332	29
30	Chair rails			1999	8,160	816	5	816		816	30
31	Painting lower level			1999	19,835	1,984	5	1,984		1,984	31
32	lower level construction walls			1999	101,713	5,086	10	5,086		5,086	32
33	cabinets			1999	46,002	1,533	15	1,533		1,533	33
34	Reg. & auto doors			1999	18,259	913	10	913		913	34
35	Equip relocation			1999	2,495	250	5	250		250	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 22,470		$ 22,470	$	$ 23,951	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Electrical work lower level			1999	29,697	1,485	10	1,485		1,485	9
10	windows/shutters			1999	15,523	1,551	10	1,551		1,551	10
11	Floor/carpeting			1999	46,503	4,650	5	4,650		4,650	11
12	Signage Interior/Exterior			1999	3,899	195	10	195		195	12
13	Plumbing lower level			1999	21,177	529	20	529		529	13
14	ECU Awnings			1999	3,994	133	15	133		133	14
15	Paneling			1999	7,309	731	5	731		731	15
16	Security System,Elevator			1999	11,010	367	15	367		367	16
17	New door hardware			1999	197	10	10	10		10	17
18	Fire alarm system upper level			1999	12,491	250	25	250		250	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 9,901		$ 9,901	$	$ 9,901	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 464,857	$ 84,386	$ 84,386	$		$ 330,892	37
38	Current Year Purchases	185,302	23,008	23,008			23,008	38
39	Fully Depreciated Assets	177,905					177,905	39
40								40
41	TOTALS	$ 828,064	$ 107,394	$ 107,394	$		$ 531,805	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transport	1995 Ford Eldorado bus	1994	$ 49,781	$ 4,978	$ 4,978	$	5	$ 49,781	42
43	Maintenance Use	2000 Isuzu truck	2000	31,007	3,101	3,101		5	3,101	43
44	General Use	2000 4-door Chrysler Sedan	2000	26,000	4,333	4,333		3	4,333	44
45										45
46	TOTALS			$ 106,788	$ 12,412	$ 12,412	$		$ 57,215	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 213,973	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 213,973	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,593,893	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Land Improvements (1993-1999)	$ 50,490	$ 614	$ 15,987	52
53	Building & Building Impr. (1990 & 1996)	739,900	36,995	224,150	53
54	Leasehold Improvments (1995-1996)	141,760	28,244	70,528	54
55	Equipment	301,712	37,528	255,221	55
56	Vehicles	62,500	3,811	6,250	56
57	TOTALS	$ 1,296,362	$ 107,192	$ 572,136	57

G. Construction-in-Progress

	Description	Cost	
58	No Construction-in-Progress	$	58
59	at year end related to this		59
60	facility		60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Berkson & Sons, Ltd.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	Allocation	0	4/96	$ 46,463	5	negotiable	3
4	Additions							4
5								5
6								6
7	TOTAL				$ 46,463 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 4/96
Ending 11/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	ease Pymts) 6/30/2001	$ 164,313
13.	ease Pymts) 6/30/2002	$ 9,184
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 9,571 Description: various office equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:	BNATP	DSP
IN-HOUSE PROGRAM	X	X
IN OTHER FACILITY		
COMMUNITY COLLEGE		
HOURS PER AIDE	87	50

3. CLINICAL PORTION:	BNATP	DSP
IN-HOUSE PROGRAM	X	X
IN OTHER FACILITY		
HOURS PER AIDE	44	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	753	1,844		2,597
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	13,735	33,627		47,362
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 14,488	$ 35,471	$	$ 49,959
10	SUM OF line 9, col. 1 and 2 (e)	$ 49,959			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 0

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	25
2. From other facilities (f)	0
DROP-OUTS	
1. From this facility	10
2. From other facilities (f)	0
TOTAL TRAINED	35

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	line 39, Col. 8	11517 hrs.	212,036			81,113		293,149	12
13	Other (specify):									13
14	TOTAL			$ 212,036		$	$ 81,113		$ 293,149	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Note: The Marklund organization does not keep separate Balance Sheets for individual residential sites. We have only one consolidated Balance Sheet for the organization.

Facility Name & ID Number Marklund Children's Home # 0011288 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,893,350	$ 1,893,350	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 18,000)	2,006,062	2,006,062	3
4	Supply Inventory (priced at Cost)	47,355	47,355	4
5	Short-Term Investments	0	0	5
6	Prepaid Insurance	47,355	47,355	6
7	Other Prepaid Expenses	63,727	63,727	7
8	Accounts Receivable (owners or related parties)	0	0	8
9	Other(specify): Client related funds	363,398	363,398	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,421,247	$ 4,421,247	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land/Land Improvements	1,041,178	1,041,178	13
14	Buildings/Build. Impr. , at Historical Cost	5,441,425	5,441,425	14
15	Leasehold Improvements, at Historical Cost	317,610	317,610	15
16	Equipment, at Historical Cost	3,083,232	3,083,232	16
17	Accumulated Depreciation (book methods)	(5,019,051)	(5,019,051)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	9,115,615	9,115,615	21
22	Other Long-Term Assets (specify): Board Restr.	1,349,213	1,349,213	22
23	Other(specify): Construction in Progress	116,732	116,732	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 15,445,954	$ 15,445,954	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 19,867,201	$ 19,867,201	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 433,777	$ 433,777	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,654	149,654	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,140	11,140	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Misc. Other Accrued Liabilities	1,392,746	1,392,746	36
37	Client related liability	363,398	363,398	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,350,715	$ 2,350,715	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,350,715	$ 2,350,715	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 17,516,486	$ 17,516,486	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 19,867,201	$ 19,867,201	48

***(See instructions.)**

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 14,204,262	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,204,262	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,389,194)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	3,371,626	11
12	Expenditures for Specific Purposes	(388,427)	12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)General exp's related to temporarily restr. donations	(69,378)	15
16	Other (describe) Change in Unrealized Gains-other than trading securities	264,374	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,789,001	17
	B. Transfers (Itemize):		
18			18
19	**Restricted Funds (Permanently held)**	123,347	19
20	**Remaining Consolidated Income**	1,399,876	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 1,523,223	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 17,516,486	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,434,002	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,434,002	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	18,315	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	11,129	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 29,444	23
	D. Non-Operating Revenue		
24	Contributions	304,162	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 304,162	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine/Cafeteria	10,266	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,266	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,777,874	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 935,916	31
32	Health Care	2,942,013	32
33	General Administration	2,329,164	33
	B. Capital Expense		
34	Ownership	370,222	34
	C. Ancillary Expense		
35	Special Cost Centers	293,149	35
36	Provider Participation Fee	296,604	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,167,068	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,389,194)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,389,194)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,934	2,080	$ 57,450	$ 27.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,237	31,080	597,972	19.24	3
4	Licensed Practical Nurses	3,041	3,236	52,852	16.33	4
5	Nurse Aides & Orderlies	117,851	125,373	1,318,641	10.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,211	2,352	52,017	22.12	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,744	1,855	24,960	13.46	10
11	Social Service Workers	2,933	3,120	41,673	13.36	11
12	Dietician					12
13	Food Service Supervisor	978	1,040	18,210	17.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,697	14,572	149,910	10.29	15
16	Dishwashers					16
17	Maintenance Workers	3,742	3,981	68,255	17.15	17
18	Housekeepers	12,365	13,154	100,494	7.64	18
19	Laundry	5,866	6,240	47,674	7.64	19
20	Administrator	2,933	3,120	82,104	26.32	20
21	Assistant Administrator					21
22	Other Administrative	12,462	13,258	246,585	18.60	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	18,774	19,972	267,402	13.39	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	5,735	6,101	60,767	9.96	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) RN/LPN Exceptior	10,711	11,517	212,036	18.41	33
34	TOTAL (lines 1 - 33)	246,214	262,051	$ 3,399,002 *	$ 12.97	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	349	$ 15,733	1	35
36	Medical Director	Monthly	31,603	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	74	4,438	10a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	475	23,728	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Recreational Thera	353	10,575	11	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,251	$ 86,077		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	3,909	73,708	10	52
53	TOTAL (lines 50 - 52)	3,909	$ 73,708		53

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terri Bowen-Weyrich	Administrator		$ 44,104
Ferdinand Ungos	Adm. Support		38,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,104

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KPMG	Audit Fees	$ 10,012
Huck Bouma & Martin,		
Jones & Bradshaw, P.C,		
and Fenech & Pachulski, P.C.	Legal Fees	18,505
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 28,517

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 101,343
Unemployment Compensation Insurance	8,834
FICA Taxes	260,024
Employee Health Insurance	208,552
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Plan	146,296
Dental Plan	17,087
TOTAL (agree to Schedule V, line 22, col.8)	$ 742,136

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	68,212
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA Dues	3,136
Misc. Licenses and Permits	5,391
Misc. Dues and Subscriptions	5,352
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,091

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,855
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,855

* Attach copy of IMRF notifications

**See instructions.

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Print Preview

Facility Name & ID Number Marklund Children's Home # 0011288 Report Period Beginning: 7/1/99 Ending: 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assoc. $3,136**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **97,704** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **296,604**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **15%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

Marklund Children's Home
#0011288
Fiscal Year 2000
Schedule V. Cost Center Expenses

Line #10 & Line #13

Reclassification:

Wages for the in-house trainer for our Nurses Aide Training Program: 47362

(This is also reflected on Schedule XIII. Expenses relating to
Nurse Aide Training Program)

Line #27

* Other includes: Fund-raising & Promotional 897006

Line #33 & Line #34
Reclassification:

Real Estate Taxes reclassed from Rent-Facility 3440
to Real Estate Taxes - based on Schedule XII. Rental Costs
instructions related to Section A., question #2.

Marklund Children's Home
#0011288
Fiscal Year 2000
Schedule VI. Adjustment Detail

Line #29

Adjustment: Non-Allowable

Real Estate Taxes	6034

Marklund Children's Home
#0011288
Fiscal Year 2000
Schedule XX. General Information

Line #14.

There is minimal space, (one classroom), that is rented to NDSEC for day school for some of our clients. There are no expenses associated with this. NDSEC supplies there own teachers, supplies, etc. We generate minimal income for the rental of this room. (See Schedule XVII., Line # 16).

Marklund Children's Home
#0011288
Fiscal Year 2000
Schedule XIX. Section C.
Summary of Legal Services

Check #	Amount	Personnel	General Business
76184	677	677	
75705	3233	1643	1590
75011	58	58	
74414	1101	1049	52
73170	495	495	
72938	68		68
71995	615	360	255
75438	5381		5381
75116	4870		4870
72145	648		648
76610	989	824	165
76704	370		370
Grand Total	18505	5106	13399

Marklund Children's Home
Schedule XIX
Seminars

Person Attending	Title	Date(s) of Seminar	Location	Sponsor/Title	Cost
Wes Kochan	Director Of Habilitation	08/23/99	Palatine, IL	Fred Pryor Seminars: Managing, Conflict, Anger & Emotion	99
Val Carson	Adminstrative Assistant	10/01/99	Schiller Pk, IL	Fred Pryor Seminars: Supervisory Skills	149
Wes Kochan	Director Of Habilitation	11/09/99	Bloomingdale, IL	Arc of Illinois : Robert Mc Namara - Abuse Prevention	80
Terri Bowen-Weyrich Sue Rusco Irene Kasnicka Wes Kochan Agnes Grahams Traci Paganucci	COO Facility Administrator DON Disrector of Habilitation RN QMRP	09/13 thru 09/15/99	Peoria, IL	Illinois Health Care Association: Annual Convention	400
Terri Bowen-Weyrich	COO	11/09/99	Itasca, IL	Lorman Education Services: Wage and Hour Law Update	267
Mary Kaltinger	RN	09/20/99	Chicago,IL	LTU Healthcare Contin. Ed. - Essential Skills for the Nurse Manager	159
Agnes Grahams	RN	09/21/99	Chicago, IL	LTU Healthcare Cont. Ed. - Power, Communication, Conflict	159
Jennifer Gozdziak Tara Stone	QMRP	May, 1999	Lisle, IL	CAMA: Communication & Manufacturing Workshop	70
Cherl Valdez	Dir. of Support Services	5/5 thru 5/6/99	Rockford, IL	Rock River Dist DMA: A New Millenium in Dietary Service	75
Mary Kaltinger	RN	01/28/00	Willowbrook, IL	PESI Healthcare: Infectious Disesases into the Millenium (Illinois)	129
Cherl Valdez	Dir. of Support Services	01/29/00	Peoria, IL	Dietary Managers Association: Sanitation	35
Val Carson	Adminstrative Assistant	06/21/00	Elk Grove Village	Pryor Resources: Grammar & Usage	99
Terri Bowen-Weyrich	COO	11/05/99	Bensenville, IL	Teresa A, Loch : Social Security 23rd Annual Employers Seminar	8
Amy Chapman Sherry Sallberg Cynthai Poniatowski	RN RN RN	11/04/99	Chicago, IL	Heritage Professional Education: Improving Clinical Documenting Skills	447
Gretchen V. Schatz	Receptionist	07/11/99	Palatine,IL	AMA/KEYE Productivity Center: How To Take Charge of the Front Desk	169
Irene Kasnicka	DON	April, 2000		Mass. Ext. Care Fed.: Care of the Medically Fragile Child in the New Millenium	250
Cherl Valdez	Dir. of Support Services	06/02/00	Spring Valley, IL	Illinois Consulting Dietician: Dietery Update-The New Millenium & Beyond	60
Cherl Valdez	Dir. of Support Services	03/13/99	Wheaton, IL	SIU: Train the Trainer	45
Nancy Rodrguez Bill Hilsabeck	Operations Assistant Information Systems Manager	04/11 thru 04/12/2000	Illinois	Compumaster: Microsoft Office	630
Val Carson	Adminstrative Assistant	04/18/00	Schaumburg	Skill Path Seminars: Front Desk Superstar	199
Myra Sandzimier	CTRS/ Resident Advocate	05/01thru 05/03/99	Lake Geneva, WI	University of Missouri: Midwest Symposium on Therapeutic Recreation	175
Laurie Colles	RN	09/18 thru 09/25/99	Wheaton, IL	Central DuPage Hospital: CPR Instructor	140
M'lis Beckham Suzanne Cruz	OT, Therpay Manager PT	11/12 thru 11/13/99	Illinois	Hampton C.A.R.E.S., INC: Treatment & Evals - OT and PT	758
Terri Bowen Weyrich Angelo D'Andrea Irene Kasnicka Wes Kochan Pat Peterman Cherl Valdez	COO Director of Facilty Services DON Director Of Habilitation Social Services Manager Director of Support Services	2/11,2/15,3/15,3/18 5/24 thru 5/31/99	Oak Brook, IL	College of DuPage: Leadership Training	618
Terri Bowen Weyrich	COO	09/15/99	Chicago, IL	Northern Illinois University: Four Roles of a Leader	463
Tom Taylor	Administrator	11/13/99	St. Charles, IL	Illinois Health Care Association: Review Course - Adminstrator	160
Judy Ramsey	RN	June, 2000		American Red Cross: CPR Instruction	12
				Total	5855

Marklund Children's Home
IDPA Cost Report
Schedule XII
Listing of Moveable Equipment

Description	Quantity
Minolta 6001 Copier	2
Zerox 3006 Fax Machine	3